

SOUTH CAROLINA ASSESSMENT & LEVEL OF CARE MANUAL
FOR
MEDICAID-SPONSORED LONG TERM CARE SERVICES

Determination of medical necessity for Medicaid-sponsored long term care services is an important function. In order to assure that those persons who need long term care services receive them, there must be a thorough screening process. It is through this process that a written evaluation is conducted of an individual's medical, psychosocial, functional, environmental, support system and service needs. Following this evaluation, a recommendation can be made about the most appropriate, least restrictive environment where care can be provided to meet the individual's assessed needs.

As the state Medicaid agency, the Department of Health and Human Services (DHHS) is responsible by law for the development, promulgation, and oversight of criteria for determining medical necessity for both institutional and home and community-based long term care services.

This Assessment and Level of Care Manual for Medicaid-Sponsored Long Term Care Services contains the following documents:

- South Carolina Level of Care Criteria for Medicaid-Sponsored Long Term Care
- South Carolina Long Term Care Assessment Form (DHHS Form 1718)
- South Carolina Long Term Care Assessment Form User's Guide

Each of these tools have been carefully linked to one another in their application and use. Therefore, in order to effectively evaluate a long term care applicant, one must have a complete knowledge of all three and understand how each is relevant to the others.

For more information about the manual, call the Department of Health and Human Services' Division of Community Long Term Care (CLTC) at (803) 253-6142 or your local CLTC Area Office or write to:

State of South Carolina
Department of Health and Human Services
Division of Community Long Term Care
Post Office Box 8206
Columbia, South Carolina 29202-8206

South Carolina Level of Care Criteria for Medicaid-Sponsored Long Term Care

Eligibility for Medicaid-sponsored long term care in South Carolina consists of meeting established criteria. In addition to meeting general, categorical, and financial eligibility requirements, an individual must also meet medical or psychobehavioral and functional requirements as determined by a screening process.

During the screening process, a comprehensive assessment of the applicant is obtained using a standardized instrument. The attached level of care criteria are applied to determine whether an individual is eligible for skilled or intermediate care.

The criteria describe the minimum services and functional deficits necessary to qualify for Medicaid-sponsored long term care. The criteria are listed under two headings, skilled and intermediate. An individual is determined to be at a skilled or intermediate level of care upon meeting the criteria. Because no set of criteria can adequately describe all the possible circumstances, a knowledge of an individual's particular situation is essential in applying these criteria.

Skilled Level of Care

A person must need at least one of the numbered skilled services (Items 1-11, adapted from the Medicare requirements at 42 C.F.R. 409.32-35 [1993]) and have at least one of the numbered functional deficits listed below to qualify for skilled level of care. A person needing item #12 by itself qualifies for skilled level of care because this represents a total care individual. In order to qualify as a skilled service, the service must be ordered by a physician, require the skills of professional or technical personnel, and be furnished directly by or under the supervision of such personnel [42 C.F.R. 409.31-35 (1993).] The need for skilled services must be clearly documented in the client's record.

Skilled Services

1. Daily monitoring/observation and assessment due to an unstable medical condition which may include overall management and evaluation of a care plan which changes daily or several times a week.
2. Administration of medications which require frequent dosage adjustment, regulation, and monitoring.
3. Administration of parenteral medications and fluids which require frequent dosage adjustment, regulation, and monitoring. (Routine injection(s) scheduled daily or less frequently [such as insulin injection] do not qualify.)
4. Special catheter care (e.g., frequent irrigation, irrigation with special medications, frequent catheterizations for specific problems.)
5. Treatment of extensive decubitus ulcers or other widespread skin disorder. (Important considerations include: Signs of infections, full thickness tissue loss, or requirement of sterile technique)
6. A single goal-directed rehabilitative service (speech, physical, or occupational therapy) by a therapist 5 days per week. Combinations of therapies will satisfy this requirement.
7. Time-limited, goal-directed, educational services provided by professional or

technical personnel to teach self maintenance, such as education for newly-diagnosed or acute episodic conditions (e.g., medications, treatments, procedures).

8. Nasogastric tube or gastrostomy feedings.
9. Nasopharyngeal or tracheostomy aspirations or sterile tracheostomy care.
10. Administration of medical gases (e.g., oxygen) for the initial phase of condition requiring such treatment, monitoring, and evaluation (generally no longer than two week duration).
11. Daily skilled monitoring or observation for conditions that do not ordinarily require skilled care, but because of the combination of conditions, may result in special medical complications. In these situations, the complications and the skilled services required must be documented.
12. This individual is totally dependent in all activities of daily living: incapable of locomotion; unable to transfer; totally incontinent of urinary or bowel function; must be totally bathed and dressed and toileted and need extensive assistance to eat.

Functional Deficits

1. Requires extensive assistance (hands-on) with dressing and toileting and eating, and physical help in bathing. (All four must be present and, together, they constitute one deficit.)

2. Requires extensive assistance (hands-on) with locomotion.
3. Requires extensive assistance (hands-on) to transfer.
4. Requires frequent (hands on) bladder or bowel incontinence care; **or** with daily catheter or ostomy care.

Note: It may be determined that an individual without a required functional deficit has special medical needs. In such cases, the individual may have a skilled medical need that warrants on-going treatment and management, which can best be addressed with skilled nursing services, as outlined under skilled services (Pages 5-6, #1-11). These cases must be referred to the State Health and Human Services Finance Commission, Division of Community Long Term Care, for special review to determine the level of care.

Intermediate Level of Care

A person can meet the intermediate level of care criteria in either of two ways:

1. by requiring at least one of the four numbered intermediate services listed below **and** having one of the numbered functional deficits listed below;
OR
2. by having at least two of the numbered functional deficits listed below.

Intermediate Services

1. Daily monitoring of a significant medical condition requiring overall care planning in order to maintain optimum health status. The individual should manifest a documented need which warrants such monitoring.
2. Supervision of moderate/severe memory, either long or short term, manifested by disorientation, bewilderment, and forgetfulness which requires significant intervention in overall care planing.
3. Supervision of moderately impaired cognitive skills manifested by decisions which may reasonably be expected to affect an individual's own safety.
4. Supervision of moderate problem behavior manifested by verbal abusiveness, physical abusiveness, or socially inappropriate/disruptive behavior.

Functional Deficits

1. Requires extensive assistance (hands-on) with dressing and toileting and eating and physical help in bathing. (All four must be present and, together, they constitute one deficit.)
2. Requires extensive assistance (hands-on) with locomotion.
3. Requires extensive assistance (hands-on) to transfer.
4. Requires frequent (hands on) with bladder or bowel incontinent care; **or** with daily catheter or ostomy care.

South Carolina Long Term Care Assessment Form User's Guide

The South Carolina Long Term Care Assessment Form (DHHS Form 1718) is designed to gather necessary information about the medical, psychosocial, and functional status of a person to determine:

1. the level of care required to receive long term care services in a nursing facility or in a community setting and,
2. service planning needs for community cases.

It is the intent that each individual being evaluated for Medicaid-sponsored long term care be aware an application is being made and to be involved if possible in the assessment process.

The CLTC Consent Form (DHHS Form 121) must be read and signed before a nurse consultant can take any official action on the assessment. The form must be signed by a responsible relative only when the client is not competent or is physically unable to do so.

The assessment information should be obtained through an interview with and observation of the person being assessed (client). Other sources of information such as family members and medical records should be utilized as necessary.

Professional judgment is used in rating the individual's medical, psychobehavioral, and functional abilities.

The Omnibus Budget Reconciliation Act of 1987 requires states' Pre-Admission Screening programs and the Minimum Data Set to be coordinated so as to avoid duplication. The instruments (Form 1718 and the Resident Assessment Instrument) are similar and will allow the state to develop a statewide long term care data base for both nursing facility and community based clients.

The Form 1718 will be required for pre-admission screening for Medicaid-sponsorship of nursing facility care, nursing facility conversions in payment source (from Medicare, VA, private pay, etc.) to Medicaid, and referral to all CLTC waiver programs

(Elderly/Disabled Waiver, HIV/AIDS Waiver, etc.)

The 1718 has been cross-referenced to the Resident Assessment Instrument. The "codes" in each of the major lettered sections of the 1718 correspond to a similar section of the Resident Assessment Instrument. This will help nursing facility staff in the transfer of the corresponding codes from the 1718 to the Resident Assessment Instrument for new admissions. This will also provide a good base line for a resident new to the facility and staff. Use of the 1718 will further expedite the resident assessment and give base information to complete the Resident Assessment Instrument within the required 14 days. The 1718 will also provide pertinent information about the resident prior to institutionalization. Secondly, the 1718 will help the nursing facility with conversion cases. The cross-referenced codes will be used to transfer data that is unchanged from the Resident Assessment Instrument to the 1718.

Instructions for Completing the South Carolina Long Term Care Assessment Form

Black ink should be used to complete the Assessment Form, DHHS Form 1718. If the assessor is unable to obtain the information requested in an item, this should be noted in the appropriate comment section. Please remember that any missing information may delay the admission review process.

Instructions are given for completing each page. The 1718 has five sections. These sections are as follows:

- Section I. Identifying/Demographic Information
- Section II. Medical Information
- Section III. Functional Information
- Section IV. Psychobehavioral Information
- Section V. Environmental/Client Outcome Information

All comments should be dated to correspond with the appropriate assessment date.

Start with Column A initially and use Columns B, C, D, and E as changes and re-evaluations occur.

Completion of Section V is for use by CLTC staff only.

The Assessment Form must be completed by a nurse, social worker, social services worker, or physician. The nurse coordinator for resident assessments is encouraged to complete this form.

It is the intent that each individual being evaluated for Medicaid-sponsored long term care be aware the application is being made and be as involved as possible in the assessment process. The assessment information should be obtained through an interview with and observation of the person being assessed (client). Other sources of information such as family members and medical records should be utilized as necessary. It may be appropriate to have the client demonstrate functional ability.

The Mental Status Questionnaire (Section IV, Part N) should be completed early in the assessment process to assist in the determination of the client's cognitive state and an ability to provide accurate assessment information. The skilled assessor may incorporate the questions of the MSQ while gathering other assessment information

such as demographic data.

The assessment form (DHHS Form 1718) can be ordered by submitting a Request for Medicaid Forms and Publications (DHHS Form 142), or by a written request to:

Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206
Attention: Support Services Supply Room

South Carolina Long Term Care Assessment Form User's Guide

Section I - Identifying/Demographic Information

These pages can serve as a referral form for clients seeking home and community-based services when submitted separately without the accompanying pages. If information cannot be obtained for a section, reference these items in the general comments (Section V of the 1718). **Gray shaded areas are to be completed by CLTC staff only.**

1. **Application Date** - date the referral is processed.
2. **Intake Manager Code** - assigned code of nurse consultant intake worker.
3. **Reason for Referral** - select the appropriate category; if for conversion, put the requested effective date.
4. **Permanent Client Information** - fill out completely; use the four digit number for year of birth; if the information is unknown, leave blank.
5. **Present Location** - indicate where the person is when the referral is made, e.g., hospital, nursing facility, home, residential care facility; if present location is the same as permanent, indicate by marking "same as above" box. **Note:** Directions only need to be completed on a person located in the community.
6. **Responsible Party** - A family member or other individual actively involved in client's care.
7. **Demographic** - choose appropriate categories.
8. **Referral Type** - choose appropriate choice.
9. **Referral Mode** - choose appropriate choice.
10. **Intake Met** - choose appropriate choice.
11. **Reason for Referral** - Indicate functional dependency or other reason for referral.
12. **Referral Source** - complete all sections.
13. **Referral Location** - Indicate where the client is located at the time of the referral.
14. **Assessment Referred To** - Indicate who is to complete the 1718.
15. **Physician Information** - give the name of the physician responsible for continuing care in the community or nursing facility; this may be a different physician than the one caring for the client while in the hospital.
16. **Financial** - complete appropriately.
17. **Signature** - Signature of person completing Section I of the 1718. (Note: only

a nurse, social worker, social services worker, or physician may complete and sign this form.)

Section II - Medical Information

This section contains current information on diagnoses, stability of condition, abnormal data, treatments and therapies, nutritional/diet regime, medications and height/weight.

A. Diagnoses - categorized in the following groups:

- Heart/Circulation
- Sensory
- Neurological
- Psychiatric/Mood
- Pulmonary
- Skin Condition
- Other
- HIV/AIDS

Coding: Indicate only the diseases present that have a relationship to current ADL status, medical treatments, or risk of death. Do not include conditions that have been resolved or no longer affect the client's functioning or care plan.

Example 1:

Code 1 = current/new (example: Diabetes Mellitus or if client has had CVA and has residual effect.)

Example 2:

Code 2 = discontinued/past history not currently treated (example: Pneumonia)

Example 3:

If a client is a quadriplegic as a result of a head injury, indicate a "1" by the diagnosis of head injury and quadriplegia.

Skin Condition: If the client has decubiti, indicate "yes" or "no", then indicate the stage in the columns as 1, 2, 3, or 4.

Stage 1 - A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

Stage 2 - A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

Stage 3 - A full thickness of skin loss, exposing the subcutaneous tissues; presents as a deep crater with or without undermining adjacent tissue.

Stage 4 - A full thickness of skin and subcutaneous tissue is lost, exposing muscle and bone.

Note: If the client has more than one decubiti, put the stage of the worst in the column and describe others in general comments.

Other: There is space available to indicate any allergies at the time of the initial assessment since these are not likely to change or need updating.

For any diagnoses not listed, use the "aaa-Other" area. Please write in the diagnoses in the space provided.

If the client is diagnosed with AIDS, indicate "bbb". If the client is HIV+, mark "ccc" and list the specific related conditions reported on the lines below. The most recent CD4 count should be indicated.

B. Stability of Condition

The intent of this item is to determine the current health status in relation to diseases/conditions present during the last 7 days, noting whether the client experiences an unstable condition and/or an acute condition episode or a flare-up of a recurrent/chronic problem.

Coding: Check **all** that apply during the last 7 days. If none apply, check item "C-None of the Above".

Examples: The item A should be used for a diabetic who requires daily or more frequent blood sugar tests in conjunction with administering sliding-scale insulin dosages. This client becomes confused when hypoglycemic. If this same client had pneumonia at the time of assessment, code item A for Unstable and item B for Acute. If a diabetic receives NPH Insulin 20 units sq QAM, requires monthly

blood sugar determinations, and has no current acute illness, code item C-None of the Above.

C. Abnormal Data

The intent of this item is to record whether the client had any known abnormal data, either lab data (i.e., blood sugar, drug levels) or abnormal vital signs during the prior 90-day period. The abnormal lab data refer to lab values that are abnormal when compared to standard values, not abnormal for the specific client.

Coding: Use the space provided to record any abnormalities and date each entry.

If no abnormal data is known, indicate in field "n/a".

D. Treatments and Therapies

The intent of this section is to identify the frequency of all treatments and therapies that the client is receiving.

Coding: Frequency codes are provided in the Section H-Medications. If the client receives no treatments or therapies, check item U-None of the Above.

For any treatments or therapies not listed, use the "T-Other" area and specify in the comments field any additions in the space provided.

E. Nutritional Approaches and Special Diets

The intent of this item is to identify nutritional approaches and specify special dietary needs.

Coding: Check **all** that apply in the appropriate alphabetical column. If the client receives no special nutritional approaches or special diet, check item T-None of the Above.

For any nutritional approaches or special diet not listed, use the "S-Other" area. Please annotate any additions in the space provided.

Note: Wasting indicates a general debilitating, weak state characterized by a

weight loss of greater than 10% in the last 60 days and resulting in a noticeable loss of muscle tone. This may be caused by an underlying disease state, i.e., HIV, cancer. Comment on weight gain or loss as appropriate in the comments section.

Nutritional Screening: This section must be completed on an applicant applying for CCM (E/D, HIV, Vent) upon the initial evaluation and re-evaluation. Completion is optional for other applicants (NH, TEFRA, etc.) Indicate all that apply to the applicant. For questions 3, 9, and 10, if any of the phrases are indicated, the entire amount of points are assigned. CMS will automatically score this section. The comment section can be used as needed.

F. Skin

The intent of this item is to record the client's current skin condition. Check as appropriate.

G. Height/Weight

Initially code the height and weight. On updates and reassessments, record only the weight, since height is not likely to vary for adults. Height and weight should be recorded on re-evaluations of clients less than 18 years old.

Note: For bilateral amputees, use pre-op height.

H. Medications

The intent of this item is to record the client's current medication use.

Coding: List the name and dosage of each drug the client is currently taking, followed by the route of administration and frequency (refer to the codes on the assessment). There is also a column for the discontinuation date of medications previously recorded on the form that are no longer current. If over eight medications are listed, complete Page 10 of the 1718. If more explanation is needed, annotate in the comments section.

There is an area to be used to annotate any medication which requires frequent monitoring or adjustment. Code 0 if "no" and Code 1 if "yes". If "yes" is coded, describe in the space provided.

Grid

This section should be completed by the assessor to indicate the date, the assessor's initials and the source of the medical information, utilizing the source codes provided on the form. The initial assessment will be completed using Column A. All subsequent updates and reassessments should be recorded in the next available alphabetical grid.

Signature

The initial assessor should also sign the form and complete the space to indicate his/her title and the date Section II was completed.

Section III - Functional Information

I. Activities of Daily Living Coding Instructions

In this section, the client's self-care performance in activities of daily living is evaluated. Use the ADL Self-Performance categories at the top of page 8 to code the ADL's: transfer, locomotion, dressing, eating, and toilet use. Separate coding categories are used for bathing and continence. The ADL self-performance categories measure what the client actually did without assistance in the last 7-14 days, indicating balance between client's self-performance and assistance caregivers provided for each activity. The assessor should use professional judgment to determine if the last 7-14 days are representative of the client's overall ADL ability. Note that codes 0, 1, 2, 3 permit one or two exceptions where heavier care is provided. This "exception" aspect of ADL codes is useful to ensure that the client is not assigned to an excessively dependent category and to increase the likelihood that the ADL items will be coded consistently and accurately.

Definitions for each of the ADL categories are included on the 1718 to guide the assessor when evaluating the client's performance in each category. Use the Comments Section to clarify or describe situations, as needed.

Note: To determine the applicable functional description for children under eighteen, the reviewer should refer to the attached guide of developmental stages of children. Code each functional activity with regard to age appropriateness. Example: A 3-month old cannot ambulate. The reviewer would code as "O" and comment "inability to ambulate is age appropriate".

Codes

Independent - Indicates the client is totally capable of completing the activity without assistance. The client can also be coded as "0" if the client received minor assistance or supervision only one or two times over the past 7 days due to special circumstances, but completed the activity independently all other times for that week. Example: Mr. U goes out one day a week to visit with family and returns in a fatigued state. He then requires help undressing prior to going to bed. He required no help that morning in dressing, and was fully self-sufficient on all other days in dressing and undressing. Thus, over the 7-day assessment period, Mr. U was fully self-sufficient 13 times and required hands-on help one time. Based on careful clinical review, the ADL codes permit this resident to be coded "0" for "Independent" in dressing.

Supervision: Indicates the client is capable of completing the activity independently with only supervision, cuing (reminders), or encouragement. **Note:** For continuous step by step instruction - see Extensive Assistance.

The client can also be coded a "1" if receiving Supervision and Limited Assistance (see code #2) only one or two times during the last 7 days, but completed the activity independently with only oversight, encouragement, or cuing (reminders) all other times for that week.

Limited Assistance - Indicates the client is capable of completing the activity with only minor assistance from caregivers.

The client can also be coded a "2" if the client received extensive assistance (see code #3) less than 50% of the time, but was capable of completing the activity with only minor assistance all other times for that week.

Extensive Assistance - Indicates the client can complete part of the activity but needs human assistance (hands-on) or verbal directions (continuous step by step direction) in relation to the activity 50% or more of the time.

The client can also be coded a "3" if receiving total assistance with the activity less than 50% of the time, but was capable of completing part of the activity all other times for that week. (Indicates hands-on assistance

needed at least 50% of the time.)

Total Dependence - Indicates the client was totally unable to assist in the activity all 7 days.

Definitions

Transfer

Indicates how the client moves between surfaces, i.e. to/from bed, chair, wheelchair, standing position (excludes to/from toileting.)

- 0 - **Independent** - Indicates total independence in transferring. If an assistive device is used, the type of device should be identified in the comments section.
- 1 - **Supervision** - Indicates that even though the person is independent is transferring, standby supervision and/or direction is necessary for safety.
- 2 - **Limited Assistance** - Indicates direction or guidance is needed for correct positioning of limbs/appliances (, sliding board), for safety, but client can transfer self.
- 3 - **Extensive Assistance** - Indicates hands-on assistance or continuous step by step direction is necessary for transfer; weight bearing includes few weight bearing steps with pivot.
- 4 - **Total Dependence** - Indicates transfer requires total human support; non-weight bearing or only able to pivot.

If during the assessment, a transfer deficit is the only identified self-performance problem, the effects of the transfer deficit on all other activities of daily living should be carefully evaluated. **Example:** If the client uses a lift chair, assess the ability to transfer from bed, toilet, etc.

Locomotion

Includes ambulation and wheelchair (electric or manually propelled) performance. A client's environment should be considered when evaluating this ADL. A client's endurance should be considered when evaluating ability to walk or propel a wheelchair.

- 0 - Independent - Indicates total independence in walking, in wheelchair, or in motor cart (i.e., client who is completely mobile in electric wheelchair). If an assisting device is used, the type of

device should be identified in the comment section (i.e., walker, cane).

- 1 - **Supervision** - With or without assistive device indicates intermittent supervision may be needed with ambulation or wheelchair use. **Example:** Slow gait but steady.
- 2 - **Limited Assistance** - Indicates guidance is needed for correct positioning of limbs/appliances (e.g., braces, prosthesis) or assistance is needed in difficult wheelchair/ambulation maneuvers (awkward thresholds, crowded areas, elevators/stairs, uneven pavement, outside) or for safety with ambulation/wheelchair. The client has the capacity to ambulate or propel wheelchair independently to a destination (more than 20 feet).
- 3 - **Extensive Assistance** - Indicates the need for physical assistance with ambulation; this need, including unsteadiness with ambulation, assistance with the application of a brace or prosthesis without which a client could not walk. If a client is wheelchair bound, indicates physical or verbal support is needed for wheelchair use.

It also indicates necessary extensive continuous verbal/hands-on direction to prevent wandering, whether because of the client's habitual tendency or his/her inability to find strategic locations (i.e., bathroom, dining room). **Definition:** Wandering indicates non-goal directed locomotion.

- 4 - **Total Dependence** - Indicates a client's total inability for walking, even though the ability remains to stand and bear weight or, if wheelchair bound, indicates total inability to operate or manually propel the wheelchair.

Dressing

Assessment should focus on the client's ability to dress self.

- 0 - **Independent** - Indicates the client is totally capable of dressing without assistance.
- 1 - **Supervision** - Indicates oversight or reminders are needed for dressing.

- 2 - **Limited Assistance** - Indicates help is needed with zippers, buttons, shoes, laying out of clothes, etc.

- 3 - **Extensive Assistance** - Indicates the client needs physical assistance or continuous verbal step by step directions in relation to appropriate dressing at least 50% of the time.

Such assistance may be needed by a client who frequently dresses inappropriately for the physical environment (i.e., many layers of clothes when the temperature does not warrant them).

- 4 - **Total Dependence** - Indicates the client must be dressed by others.

Eating

Code appropriately relative to the activities the client is capable of accomplishing within a reasonable length of time for a meal. The amount of food consumed in order to ensure adequate nutritional intake should also be considered.

Outside a long term care facility, "setting up the meal" is defined as a person's ability to take prepared food, warm it and serve it for eating. Since these activities would not be appropriate in nursing facilities or residential care facilities due to licensing and certification standards, staff of the facility should evaluate the client's ability to accomplish these activities.

- 0 - **Independent** - Indicates no assistance is needed in setting up and eating the meal. Setting up the meal is defined as a person's ability to take prepared food, warm it, and serve it for eating.

- 1 - **Supervision** - Indicates oversight or reminders are needed for meal preparation and/or to eat meals.

- 2 - **Limited Assistance** - Indicates help is needed in cutting meat, opening prepackaged items, and so forth.

- 3 - **Extensive Assistance** - Indicates the need for physical assistance with or continuous step by step directions pertaining to eating and/or setting up the meal at least 50% of the time.
- 4 - **Total Dependence** - Indicates the client is totally dependent on another for feeding.

Toilet Use

Indicate how the client uses the toilet (i.e. commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

If bowel/bladder training is in progress, indicate this in the comment section of the continence section. If toileting is done at bedside, using bedpan or commode, indicate in the comments section if the client has any measure of independence.

- 0 - **Independent** - Indicates that no assistance is required for toileting.
- 1 - **Supervision** - Indicates oversight is needed for safety in toileting.
- 2 - **Limited Assistance** - Indicates help is needed with arranging clothes or emptying bedpan/bedside commode.
- 3 - **Extensive Assistance** - Indicates routine physical or continuous step by step direction for transfer and/or personal hygiene. This may include a person who frequently toilets in inappropriate places (i.e., floor vents, dresser drawers).
- 4 - **Total Dependence** - Indicates total assistance.

Bathing

This activity rates the maximum amount of physical assistance the client requires in order to achieve safe and adequate hygiene. Code the maximum amount of assistance client receives. Physical help in part of bathing activity (washing off) indicates that client needs assistance in a part of the bathing activity at least 50% of the time (excludes washing of back and hair.)

- 0 - **Independent** - Indicates no physical assistance or direction is needed with routine daily bathing.
- 1 - **Supervision** - Indicates standby oversight or supervision is necessary to ensure safety and completion, regardless of method of bathing.
- 2 - **Physical Help Limited to Transfer Only** - Indicates physical assistance is needed to move from one surface to another (example: getting in and out of tub/shower), but no assistance is needed with bathing activity or assistance needed less than 50% of the time (excludes washing of back and hair).
- 3 - **Physical Help in Part of Bathing Activity** - Indicates necessity hands on physical assistance or continuous step by step direction is needed in bathing 50% or more of the time (excludes washing of back and hair).
- 4 - **Total Dependence** - Indicates total hands-on assistance is required in bathing.

Continence

These categories are to be used to code the pattern of bladder and bowel continence/control during the last 14-day period. Use the codes provided on the 1718, Page 8-Continence.

- 0 - Indicates complete control. **Note:** This would be counted as a deficit when indwelling catheter is in place and not self care.
- 1 - For bladder-Indicates incontinent episodes once a week or less; For bowel-Indicates less than weekly
- 2 - For bladder-Indicates 2+ times a week but not daily; For bowel-Indicates once a week.
- 3 - For bladder-Indicates frequent incontinence, but some control, **OR** if the client is being toileted (extensive assistance) on a regular basis,

i.e., every 2 hours; For bowel-Incontinent 2-3 times a week.

- 4 - Indicates total incontinence and no control (or an indwelling catheter/ostomy that controls the client's bladder/bowel (without leakage).

Use of appliances and/or self-care should be indicated by an "N" or "Y" in the appropriate box(es) on the 1718.

Note: If the client is incontinent, but self-care indicated, this does not constitute a deficit.

- J. Modes of Transfer - Select all that apply.
- K. Modes of Locomotion - Select all that apply.
- L. Appliance/Programs - Select all that apply.
- M. Communication

Select the appropriate description and indicate by placing the corresponding number in the appropriate box by each of the four categories. Comment on any prosthesis and/or appliances the client uses.

Modes of Expression: Indicate all that apply.

- N. Vision

Select the appropriate description and indicate by placing the corresponding number in the column. Comment on any prosthesis and/or appliances the client uses.

Section IV - Psychobehavioral Information

Note: For children under age twelve, completing of this section is not required but comments should be made. Briefly describe the behavioral manifestations of daily habits or psychological problems. The assessor is not diagnosing, but reporting observable behavior.

- O. Cognitive Patterns

Comatose

Indicates a state of unconsciousness from which a client cannot be aroused by verbal or light tactile stimuli; no communication skills.

Record the appropriate number in the box. If a client is comatose, enter "1", then STOP Section IV here.

Memory

Coding for this section:

- 0 - No problem to minimal problem
- 1 - Moderate to severe problem
- 2 - Unable to rate

Short-term memory - Ask the client to describe a recent event. For example, ask the client to describe the breakfast meal, an activity just completed, or object recall, and rate accordingly using the appropriate number.

Long-term memory - Engage in conversation that is meaningful to the client. Ask questions for which you already know the answers (from your review of record, general knowledge, family.) For example, "Are you married?", "What is your spouse's name?", "Do you have any children?", "How many?", "When is your birthday?". Rate accordingly.

If the client has a moderate/severe problem, comment as to the degree of the problem and cite an example in the comments section.

Cognitive Skills for Daily Decision Making (Judgment)

Select appropriate description and code.

- 0 - **Independent** - The client's decisions are consistent and reasonable, reflecting lifestyle, culture, values. The client organizes daily routine and makes decisions in a consistent, reasonable, and organized fashion.
- 1 - **Modified Independence** - The client organizes daily routine and makes safe decisions in familiar situations, but experiences some difficulty in decision making when faced with new tasks or situations.
- 2 - **Moderately Impaired** - The client's overall decisions are poor. The client requires reminders, cues, and supervision in planning, organizing, and correcting daily routines. Note: Cite an example in the Comments Section.
- 3 - **Severely Impaired** - The client's overall decision making is severely impaired. The client never (or rarely) makes decisions. Note: Cite an

example in the Comments Section.

P. Mood and Behavior Patterns

Select the code that most appropriately describes:

Sad or Anxious Mood - This behavior **pattern** presents as distressed mood characterized by explicit verbal or gestural expressions of feeling depressed or anxious (or a synonym such as feeling sad, miserable, blue, hopeless, empty, or tearful.) **Note:** Specify behavior in the comments section.

Problem Behavior - Four categories are listed. Code appropriate categories and specify behavior in the comments sections. Comment on past behavior if pertinent to current condition.

Q. Mental Status Questionnaire

Code as appropriate. The total MSQ score is the number of incorrect answers. **Note:** The MSQ is to be used only for a client 12 years or older.

R. Comments

Record pertinent additional information and date each entry.

Signature of Person Completing the Assessment Form

The individual who completes the initial assessment form must sign and date the form and indicate his/her title in the space provided at the end of Section IV. Only nurses, social workers, social service workers, or physicians may complete this form.

Grid

Place the date the corresponding column was completed and the initials of the person completing the form. **Gray Grid is for CLTC use only.**

Section V - Environmental/Client Outcome Information - CLTC Use Only

This section is to be completed by the CLTC nurse consultant and case manager.

Instrumental Activities of Daily Living and Residence will be completed only on community case management cases upon initial assessment and at re-evaluation.

S. Client Outcomes

Client outcome information will be annotated on all clients. Enter the date of action that the client entered the CLTC program or terminated. Use the code to indicate which CLTC program entered or the termination codes to show the reason for termination.

T. Nursing Facility Certification

Circle the appropriate level of care and annotate the effective date and expiration date of certification. Certifications are issued for 30 days unless a time-limited certification is given. If this is the case, the end date of the time-limited certification is the expiration date. Circle the appropriate response to indicate if the certification is time-limited and the name of the nursing facility, if known.

U. Instrumental Activities of Daily Living

Instrumental Activities of Daily Living will be completed only on community case management cases upon initial assessment and at re-evaluation.

Using the codes 1 = Independent, 2 = Some Assistance, and 3 = Dependent, respond to the 7 items that relate to the client's ability to perform instrumental ADL's. Use the comments section if further explanation is needed for clarification of an entry. Example: Medication - If coded limited assistance, an example comment would be "medications require set up".

V. Residence

This Section will be completed only on community case management cases upon initial assessment and re-evaluation. Using the codes 1 = yes and 2 = no, respond to the nine items that relate to environmental factors which relate to the client's residence. Use the Comments Section if further explanation or clarification is needed.

Guide to Developmental Stages of Children

1 Month

- Eyes follow bright moving object
- Responds to noises
- Makes throaty noise
- Makes crawling movements when prone
- When held in standing position, body limp at knees and hips
- In sitting position back is uniformly rounded, absence of head control

2 Months

- Turns from side to back
- Begins to lift head, smiles
- Some eye coordination, follows sounds
- Anticipates being fed, put hands in mouth
- When prone, can lift head almost 45 degrees off table
- When held in sitting position, holds head up but head bobs forward

3 Months

- Holds head high, makes crawling movements when prone
- Has fairly good head control, turns head to follow people
- Holds objects in hands
- Smiles, coos
- Focuses and follows objects
- Able to hold head more erect when sitting, but still bobs forward
- When held in standing position, able to bear slight fraction of weight on legs

4 Months

- Laughs, cries for attention
- Rolls from back to side
- Listens, turns head to sound
- Holds objects, takes to mouth
- Sleeps through the night, has naptime
- Recognizes mother, responds to "no"
- Able to sit erect if propped up

6 Months

- Sits in high chair with back straight
- When held in standing position, bears almost all of weight

7 Months

- 2 central lower incisors
- Double birth weight
- Bears full weight on feet
- Rolls over easily
- Starts to talk "Ma" "Da"
- Laughs
- Frets when mother leaves
- When held in standing position, bounces actively

8 Months

- Sits steadily unsupported
- Readily bears weight on legs when supported, may stand holding on

9 Months

- Crawls, may progress backward at first
- Sits steadily on floor for prolonged time (10 minutes)
- Pulls self to standing position and stands holding onto

furniture

10 Months

- Sits without support
- Pulls self up
- Can hold bottle and feed self crackers
- Claps hands
- Can drink from cup
- 4 upper incisors
- Crawls by pulling self forward with hands
- Pulls self to sitting position
- Stands while holding onto furniture, sits by falling down

12 Months

- Shows anger, fear, affection
- Triple birth weight
- Begins to stand alone and toddle
- Has 2 lower incisors
- Uses spoon
- Builds blocks (2)
- Tries to toss objects
- Has regular B.Ms.
- Attention span increases
- Cruises or walks holding onto furniture or with both hands held
- Walks with one hand held
- May attempt to stand alone momentarily
- Can sit down from standing position without help

15 Months

- Walks without help (usually since age 13 months)
- Creeps up stair
- Assumes standing position without support
- Uses cup well but rotates spoon
- Feeds self using regular cup with little spilling

18 Months

- Runs clumsily, falls often
- Walks upstairs with one hand held
- Seats self on chair
- Manages spoon without rotation, but some spilling
- Takes off gloves, socks, and shoes and unzips

24 Months

- Uses short sentences
- Obeys simple commands
- Walks up and down stairs, has steady gait
- Holds cup for drinking
- Feeds self with spoon
- Kicks ball, builds 4 to 6 block tower
- Rides tricycle
- Uses "mine - no" words
- Resists bedtime
- Cooperates with toilet training
- Clings to parents
- Routine is important
- Has 4 cuspids
- Runs fairly well, with wide stance
- Dresses self in simple clothing

- Has full set of teeth (20)
- 4 second molars

3 Years

- Plays with others - takes turns
- Colors
- Begins 5 lb. weight gain per year
- Rides tricycle, dances, jumps, swings and climbs
- Knows and gives full name
- Talks in short sentences
- Undresses self, washes and dries hands
- Feeds self with spoon
- Begins to handle short separation from parents
- Begins to identify genders
- Jumps with both feet
- May attend to toilet needs without help except for wiping
- Goes up stairs using alternate feet, may still come down using both feet on the step
- Buttons and unbuttons accessible buttons
- Pulls on shoes

4 Years

- Buttons front and side of clothes
- Adds 9-10 inches to height
- Laces shoes
- Baths self with directions
- Brushes teeth
- Climbs and jumps well
- Tries to print letters
- Learns some numbers, colors
- Asks many questions and uses language
- Performs simple tasks
- Keen observer
- Skips and hops on one foot
- Walks down stairs using alternate footing

5 Years

- Gains 7 lbs. per year (varies)
- Has good motor control
- Washes self
- Height increases 2½ inches per year (varies)
- Prints first name and other words
- Talks constantly
- Participates in conversations, asks for definitions
- Begins to lose baby teeth; permanent teeth appear about 4 per year from 7-14 years
- Knows age and residence
- Knows weeks, days of week, colors
- Counts to 10, can copy a triangle
- Is obedient, reliable and sympathetic
- Eyes become fully developed
- Protective toward younger children
- Accepts responsibility for actions, is less rebellious
- Shares toys
- Skips and hops on alternate feet
- Balances on alternate feet with eyes closed
- Ties shoelaces
- Cares for self totally, occasionally needing supervision in dress or hygiene